EXHIBIT 18

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	MDL No. 1456 Master File No. 01-CV-12257-PBS Subcategory Case No. 06-11337
THIS DOCUMENT RELATES TO: United States of America ex rel. Ven-A-Care of the Florida Keys, Inc., et al. v. Dey, Inc., et al., Civil Action No. 05-11084-PBS, and United States of America ex rel. Ven-A-Care of the Florida Keys, Inc., et al. v. Boehringer Ingelheim Corp., et al., Civil Action No. 07-10248-PBS	Hon. Patti B. Saris VIDEOTAPED DEPOSITION OF THE INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION by CARL MARK SHIRLEY, R.Ph. VOLUME I

DECEMBER 2, 2008

INDIANAPOLIS, INDIANA

E X H I B I T S (CONTINUED)

P R O C E E D I N G S

VIDEOGRAPHER: On the record at 9:07 a.m. on December 2nd, 2008. Here begins the videotaped deposition of Mark Shirley on behalf of the State of Indiana Family and Social Services Administration.

This case regards the Pharmaceutical Industry Average Wholesale Price Litigation, MDL No. 1456, in the United States District Court, District of Massachusetts.

This deposition is taking place at the Hilton Hotel, 8181 N. Shadeland Avenue, Indianapolis, Indiana.

My name is James David, Certified Legal Video Specialist. And our court reporter is Dana Miller. We're both working with Henderson Legal Services.

Will our counsel please state your appearance for the record.

MR. JULIE: My name is Douglas Julie from Kelley, Drye & Warren. And I'm counsel for

defendants Dey, Inc., Dey L.P., Inc. and Dey, L.P.

MR. BIPPUS: And -- go ahead.

MR. COOK: I'm Christopher Cook from Jones Day representing Abbott.

MR. BIPPUS: And Gary Bippus from the Office of the Indiana Attorney General.

MR. LINNEWEBER: Scott Linneweber, L-I-N-N-E-W-E-B, as in boy, E-R, Family and Social Service Administration.

MS. ST. PETER-GRIFFITH: Ann St. Peter-Griffith from the United States Attorney's Office, Southern District of Florida on behalf of the United States.

VIDEOGRAPHER: Will our court reporter please swear or affirm the witness.

CARL MARK SHIRLEY, R.Ph., having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, relating to said matter, was examined and testified as follows:

EXAMINATION

BY MR. DOUGLAS JULIE:

Q. Good morning, Mr. Shirley. Thank you for making yourself available today. Can I ask you to please state and spell your name for the record.

A. Yes. My name is Carl Mark Shirley, that's C-A-R-L M-A-R-K S-H-I-R-L-E-Y.

Q. Thank you. And are you here today to -- are you here today on behalf of the Indiana Family and Social Services Administration?

A. Yes.

Q. You're their corporate designee?

A. Yes.

Q. Thank you. As I stated before, my name is Douglas Julie. I'm counsel for Dey, Inc., Dey, L.P., Inc. and Dey, L.P. I'll refer to those three collectively today as Dey.

Are you currently on any medications which might affect your memory?

A. No.

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MR. JULIE: Yes.
MR. BIPPUS: All right.
BY MR. JULIE:
Q. Are you, Mr. Shirley, are you prepared to testify to all of the topics contained in Exhibit 1 of this subpoena?
A. Yeah.
MS. ST. PETER-GRIFFITH: Object to the form. Go ahead.
A. Again, to the extent I have knowledge.
Q. And I guess going back to what Gary said, have you seen that the State of Indiana has designated portions of Mr. Sharp's testimony as responsive to the -- from his prior deposition as responsive to the subpoena?
A. I do not understand your question.
Q. I received a document this weekend from Mr. Bippus stating that the State of Indiana was designating portions of Mr. Sharp's testimony as responsive to this deposition (sic) in addition to your testimony here today being responsive to this subpoena.

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A. Okay.
Q. Do you understand that?
A. Now that you've told me.
Q. Okay. Well, having not -- had you not heard that before?
A. No, I was not aware of that.
Q. Okay. So do you -- you have not been told that your designation as Indiana Medicaid's witness is limited by -- in any way by the designation of Mr. Sharp's testimony?
A. Again, I'll ask you to restate that question.
Q. Sure. You have not been instructed by counsel that your designation as the witness for Indiana Medicaid here is in any way limited by Indiana's decision to designate Mr. Sharp's testimony?
A. That was not communicated to me.
Q. Thank you. What is your position with Indiana Medicaid?
A. It's Pharmacy Operations Manager, is the title. I believe the job description calls

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it chief pharmacist.
Q. And what does your job entail?
A. As the title implies, it's operations management. And myself with other staff have oversight of contractors.
We have contractors that perform a variety of services. In fact, the Indiana Medicaid pharmacy benefit is heavily contracted out. So a lot of it has to do with oversight and management of contractors, making sure that we get deliverables on time, monitoring for quality.
My position also calls for oversight of the state's drug utilization review board and therapeutics committee meetings. And those are meetings of advisory bodies to the office.
There's also a quality advisory committee which has to do with policy pertaining to mental-health drugs. I have an assisting role in that.
I'm over the oversight of the federal and state supplemental rebate programs. And that is, once again, back to the contractor oversight

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function. That is handled on a day-to-day basis by our contractor, ACS.
Q. I'm sorry, is ACS an acronym or is --
A. Stands for Affiliated Computer Systems.
Q. Thank you. And what does ACS do for the state?
A. ACS is our designated PBM services vendor. And in that capacity, they provide for prior authorization services, preferred drug lists support, related report development, and the federal and state supplemental rebate programs administration.
Q. Has ACS served in that role for the last 20 years for Indiana?
A. No. I believe since 2003, if memory serves me correctly.
Q. Was there another company that served in that role prior to 2003?
A. EDS had been our claims processor, some people refer to it as PBM function, I don't believe it was necessarily a PBM function in the conventional sense, but they did handle our

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claims processing for us and fiscal agent contractor responsibilities.
Q. Thank you. Does Indiana Medicaid still contract with EDS for any functions?
A. Yes, yes.
Q. What does Indiana Medicaid contract with EDS for currently?
A. In the sense of pharmacy, it's claims processing and provider relations support. They handle provider enrollment functions. And it's basically a claims-functioning process.
Q. And for how long has EDS, generally has EDS provided claims-processing services to Indiana?
A. I can't tell you any specific number of years. EDS has been a claims processor for Indiana Medicaid for some time.
There was a period of time during which ACS at the beginning of their contract as PBM services vendor did provide claims support, and that was subsequently then returned backed back to EDS.

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So EDS has processed and adjudicated claims for some time with the interruption during which -- or the period of time during which ACS handled the claims processing.
Q. Thank you. How long have you been in your current position at Indiana Medicaid?
A. Since November of 1981.
Q. Prior to November 1981, did you have a different position at Indiana Medicaid?
A. Yeah, I should probably clarify that. Since November of '81, I've been an employee of the State. Had always been with the pharmacy benefit under the state Medicaid program.
Q. So have you had different titles since -- during that time?
A. Initially the title I came on as, quote/unquote, chief pharmacist. And I think that was primarily due to a position, just fill-in-the-block-type thing.
I don't think the state had ever had a pharmacist with the state Medicaid pharmacy benefit. I think the personnel situation called

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for pharmacists' positions primarily at state-operated facilities. And in those facilities, they would have had pharmacists and chief pharmacists. And in order to accommodate my salary needs at the time, they were able to get me in the position of chief pharmacist.
So while chief pharmacist was the block at the personnel level, I had been referred to as the pharmacist, the pharmacy consultant, and pharmacy director.
Q. Okay. And in that role as chief pharmacist, what were your responsibilities?
A. From the beginning, basically to handle anything regarding pharmacy. And that was at the outset retail pharmacy relations with retail pharmacies as providers. The state had just started a prior authorization program in 1981. I came on at the advent of that. I think that was one of the reasons for the creation of the position, was that they had prior authorization for certain services rendered by pharmacies.
So they needed a pharmacist to oversee

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and manage that. And anything having to do with pharmacy, per se, was in my scope of responsibilities.
Q. Okay. And did your -- has your title changed at any point?
A. Other than what I mentioned, no, it's been substantially the same.
Q. Thank you. Have you been employed continuously by Indiana Medicaid --
A. Yes.
Q. -- since 1981? Do you understand the time period that you're designated to testify to here today?
A. December '91 to present.
Q. Are you available to testify regarding facts that might have occurred in the 1980s?
MS. ST. PETER-GRIFFITH: I'm going to object to the form.
Q. You can still answer.
A. My answer to that would be no. I would not want to testify to something that would go that far back.

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reimbursement amounts into ingredient portion and a dispensing-fee portion?
A. The reimbursement for pharmacy reimbursement is comprised of estimated acquisition cost plus dispensing fee, if applicable, MAC plus dispensing fee, if applicable, and usual and customary charge.
So you had said aside from the state MAC -- or excuse me, the usual and customary piece, set that aside, then your two remaining possible pieces of the algorithm would be EAC and state MAC.
Q. Okay. And on usual and customary-based reimbursement, there is no dispensing fee paid to providers?
A. It's very important to understand that the providers submit a charge, which is his usual and customary charge, may or may not at that provider's discretion include a dispensing fee. That's totally up to the provider.
Q. And if a provider submitted a claim that contains a usual and customary charge, that

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-- I'm sorry. A provider can submit a claim that expresses its usual and customary charge in two parts, a part with a dispensing fee and another part?
A. No, we do not allow for that. The only thing the program accepts and has instructed providers is to submit their usual and customary charge, which if the provider has a dispensing fee of their own, that is part of their usual and customary charge.
Q. I'm not sure I understand what you mean by dispensing fee with respect to usual and customary charge.
A. If a provider has a charge to you as a customer, they're going to typically make that charge up out of what they pay for the drug in some fashion somehow, and something that they use to cover their overhead and everything else associated with the running of the pharmacy. They blend that all together, and that becomes their usual and customary charge.
That's what we have told them to

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submit. We do not tell them bill us only for some amount having to do with the drug and we, Medicaid, will put a dispensing fee on top of that. We never do that.
Q. Okay. So -- all right, now I believe I understand. So you're saying that when a provider -- you know, I think you've said it. There's no reason to summarize.
A. It's complicated.
Q. You stated that one of the ways that Indiana reimburses for pharmaceuticals, Indiana Medicaid reimburses for pharmaceuticals, is that there is reimbursement for EAC --
A. Yes.
Q. -- and a dispensing fee. Is EAC estimated acquisition cost?
A. That's correct.
Q. When considering the adequacy of reim -- pardon me, strike that.
When considering whether the state is providing adequate reimbursement for a covered product, does the state consider both the

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ingredient portion and the dispensing-fee portion as needing to be adequate?
MS. ST. PETER-GRIFFITH: Object to the form.
Q. Do you think of those issues together as providing that total reimbursement must be adequate, or does reimbursement for each individual component need to be adequate?
MS. ST. PETER-GRIFFITH: Object to the form.
A. Once again, my sense on this is that ultimately your reimbursement for the service must be adequate to ensure participation by providers. And my sense is that providers probably don't much care one way or the other which side of the equation is which, as long as what they get from Medicaid is sufficient for them to render service.
So I think, you know, we act administratively in light of that. It makes sense to have a total reimbursement that is sufficient to maintain provider participation.

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A. Yes.
Q. Can you very briefly, because I may get to this later, can you tell me your understanding of the difference between brand and generic drugs?
What was Indiana's understanding of the difference between brand drugs and generic drugs?
A. Difficult to answer that question. The difference between brand and generic drugs, according to the FDA, is there is no difference.
Generic drugs that are therapeutically substitutable for band-name drugs are the same. But if you're talking about reimbursement, that's a different issue. So I'm trying --
Q. I am talking about reimbursement, sir.
A. -- to find where you're going.
Q. Thank you.
A. So would you clarify the question.
Q. Sure. This document, we've said, distinguishes between brand-name drugs and generic drugs for purposes of reimbursement; that's correct?

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A. Yes.
Q. By generic drugs, does the plan mean to reimburse at a separate rate for innovator drugs and non-innovator drugs?
A. In looking at this document, the only thing I can say is that there is clearly a difference in policy as to how the state is going to reimburse for brand-name drugs and for generic drugs.
Q. Okay. If I was a provider or I worked for EDS and I wanted to know which drug fit the brand-name formula and which drug fit in for the generic formula, how would I go about determining that?
A. I believe that would come from the First DataBank file that they use in claims processing.
Q. So the distinction here is a distinction drawn on -- from First DataBank?
A. First DataBank and if there is any algorithm that would be developed to pay elements from the First DataBank file that says if you

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look at this, this and this equals generic, if you look at this, it's brand name.
Q. Thank you. On this document it also appears that the state has instituted for the first time a state Maximum Allowable Cost program?
A. Yes.
Q. Is that -- is this your recollection as to chronologically the origin of the state MAC program?
A. Yes.
Q. And charges for federal upper limit and usual and customary-based reimbursement have been retained --
A. Right.
Q. -- in this plan?
A. Yes.
Q. Thank you. I'm going to ask you about the state MAC program a little later, but can I ask you now, why did Indiana switch from an AWP minus 10 EAC for all legend drugs to a bifurcated AWP minus 13 for brand-name drugs and AWP minus

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20 for generic drugs?
A. I believe at the time the perception was that generic drugs, AWP information was not as accurate for generic drugs as it was for brand-name drugs, that is there was a greater spread on generic drugs.
And if I also remember, it seems like there was some input from other states that using AWPs on generic drugs, you should have a higher percentage off of your AWP for your EAC.
Q. When you say generic drug -- I'm sorry, strike that.
You had stated that AWP information was not as accurate, though you didn't specify by what reference you were measuring its accuracy. Can you just tell me a little bit about what you were --
A. I think there was a general perception that the AWPs for generic drugs were inflated. Seems like there was also some information from OIG or GAO or both or CMS or all three that questioned the use of AWPs on generics. And,

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again, I'm going strictly by memory on this.
It seems like that was part of the thrust behind the bifurcation of the reimbursement methodology for the two different types of legend drugs.
Q. But you had specifically used the word that it was not as accurate. And it may very well be that you did not mean to use the word. But I'm just wondering whether when you said accurate, if you were considering whether AWP -- when you think about AWP accuracy, with what are you referencing it as a guidepost? If something is inaccurate, it must be --
A. I think it all has to do with this issue that people have called the spread, the relationship between the published AWP of a drug and an amount that a provider actually ends up paying for the drug.
And it seemed like for generics, it was the case that there was this greater spread between the AWP and the actual acquisition cost. And I think that was probably what was behind the

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taking generics to go to a minus 20 percent as opposed to say the minus 13 1/2.
Q. Because Indiana wanted to get closer to -- get AWP-based reimbursement closer to the spread -- I'm sorry, strike that.
Did you understand -- I'm sorry, did Indiana Medicaid understand at the time that it moved in 2002 from AWP to minus 10 to AWP minus 20 for generics, did Indiana understand that it was not necessarily capturing all of the spread between average wholesale price and average acquisition costs in discounting average wholesale price?
A. Repeat that question.
Q. Did Indiana understand that when it moved in -- I'm sorry, strike that.
Can you think of any other considerations that Indiana made other than information disclosed from CMS that caused it to make this switch to -- both to bifurcate brand and generic and to switch to generic minus 20?
A. Looking at the time frame of this,

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which would have been 2002, and again I'm thinking of Myers & Stauffer's role, they typically provided analytic support to the office on cost-containment initiatives. And this was probably driven partially at least by some type of cost-containment initiative. There may have been information provided by Myers & Stauffer one way or the other about, you know, this is where the other states are on generics, and this is what the market looks like, and this is what this study shows. I don't know that for a fact one way or the other.
It could be, possibly not, but that's one possible source of additional information, would have been input from Myers & Stauffer.
Q. Can you think of any other considerations that Indiana made at the time?
A. Well, obviously, going through the rule- promulgation process, we would have considered all public comments.
And not knowing right here what the public comments were that were made during the

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public hearing for the initiative, it's possible that there would have been other comments from the public. And the record of the public hearing, I'm sure, would show that.
Q. What role did Indiana's understanding of the prices at which pharmacies could obtain pharmaceutical products play into the decision to reduce the reimbursement for generic drugs to minus 20 percent?
A. State that again, please.
MR. JULIE: Can you re-read that.
(The requested material was read back by the reporter.)
A. I quite sincerely do not understand the question.
Q. Okay. Then I'll reask it a different way. When Indiana decided to reimburse for generic drugs at AWP minus 20 percent, did it consider in that decision-making process its knowledge of pharmaceutical prices available to provider pharmacies?
A. I'm not certain of the analytic